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NAME OF EMPLOYER
SERVICE COMPANY
ADDRESS
5 5 1 4 T E S T S T R E E T
CITY T A L O
NAME OF ATTORNEY / REPRESENTATIVE
ADDRESS
ADDRESS
CITY STATE ZIP
BRIEF DESCRIPTION OF ILLNESS OR INJURY:
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PART III - INFORMATION ABOUT YOUR SPOUSE/OTHER FAMILY MEMBER
1) Do you have any group health plan coverage based upon your spouse's/other family member's current
employment? YES NO Mo If no, sign on the bottom of the form.
2) How many employees, including your spouse, work for the employer from whom you have health insurance?
1-99 100 or more
Please print the name of the spouse's/other family member's current employer, and information about the
employer group health plan in the spaces below:
employer group health plan in the spaces below: EMPLOYER NAME
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